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MENTAL HEALTH AND PSYCHIATRIC NURSING IN PRACTICAL NURSE EDUCATION. FINAL REPORT.

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THIRTY-ONE PROFESSIONAL NURSE EDUCATORS IN SCHOOLS OF PRACTICAL NURSING IN THE SOUTHEAST ATTENDED A TWO-WEEK CLINICAL WORKSHOP ON PSYCHIATRIC NURSING AT WESTERN STATE HOSPITAL, STAUNTON, VIRGINIA, IN AUGUST 1966. THEY RECONVENED FOR A THREE-DAY FOLLOW-UP CONFERENCE AT ATLANTA, GEORGIA, IN JANUARY 1967. THE PROJECT WAS UNDERTAKEN TO UPDATE THE INSTRUCTORS' KNOWLEDGE AND SKILLS IN MENTAL HEALTH AND PSYCHIATRIC NURSING, AND TO DEVELOP EDUCATIONAL OBJECTIVES, CURRICULUM, INSTRUCTIONAL MATERIALS, AND PROCEDURES FOR USE IN PRACTICAL NURSE INSTRUCTION. A PROJECT DIRECTOR, THREE MENTAL HEALTH-PSYCHIATRIC NURSING SPECIALISTS, THREE CLINICAL NURSING INSTRUCTORS, AND PROFESSIONAL STAFF MEMBERS FROM WESTERN STATE HOSPITAL AND DEJARNETTE SANITARIUM SERVED AS FACULTY. TRAINEES PARTICIPATED IN STAFF CONFERENCES, GROUP AND INDIVIDUAL INSTRUCTION (INCLUDING LECTURE DISCUSSION SESSIONS), CLINICAL PRACTICE WITH PATIENTS, AND ONE FIELD TRIP. THEY PREPARED INSTRUCTIONAL MATERIALS AND UNDERTOOK THE INTEGRATION OF MENTAL HEALTH AND PSYCHIATRIC NURSING CONTENT INTO THE CURRICULUM. DURING THE FOLLOW-UP CONFERENCE FACULTY AND TRAINEES REVIEWED PROGRESS MADE AND PROBLEMS ENCOUNTERED, REFINED THE ORIGINAL INSTRUCTIONAL MATERIALS, AND MADE RECOMMENDATIONS FOR FURTHER ACTION. (THE DOCUMENT INCLUDES REFERENCE AND STUDY MATERIALS, FILMS, AND NINE OTHER APPENDIXES.) (LY)

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U. S. DEPARTMENT
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FINAL REPORT – Project No. 6-2129 – Grant No. OEG 2-6-062129-0724

Annie Laurie Crawford

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The response and continuing interest expressed by directors of state departments of vocational education, in a very real sense, predict the impact of the project on improving and expanding nursing services in mental health programs.

Members of the administrative staff of the Southern Regional Education Board and the mental health training and research staff have been both constant and consistent in their helpfulness.

A special appreciation is due trainees, whose enthusiasm was a continuing stimulus to the faculty, and whose diligence produced materials of quality and quantity beyond our expectations.

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ANNIE LAURIE CRAWFORD
Project Director

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BACKGROUND AND NEED

The clinical workshop and follow-up conference described in this report were designed to promote improvement and expansion of mental health and psychiatric nursing instruction in practical nurse schools in the states participating in the Southern Regional Education Board* mental health training and research program. The project was planned in response to statements of need by administrators of psychiatric services, and requests of practical nurses that mental health and psychiatric nursing instruction be included in curricula of schools.

Historically, most of the nursing care of the mentally ill has been provided by on-the-job trained workers. The need for nursing personnel in psychiatric services who have pre-service education in nursing has been recognized by many mental health program leaders.

Recent developments in treatment programs have made this need more explicit and urgent. Extensive use of drugs in treatment requires nursing personnel qualified to administer medicine and to observe and record changes occurring in patients who are receiving drugs. Increasing numbers of psychiatric patients are being treated in general hospitals and other community facilities, including nursing homes. Substantial numbers of licensed practical nurses are already employed in these facilities. The demand for many more is well illustrated in reports and recommendations which have been published recently.

A 1959 survey reported no budgeted positions for licensed practical nurses in state hospital nursing services in Oklahoma. A program which included instruction of practical nurse students in a psychiatric facility was developed in 1960. In 1965, Oklahoma reported 68 budgeted positions in state hospital nursing services.

Two Veterans Administration hospitals in one Southeastern state reported that they employ 32 licensed practical nurses and "would like more."

A number of states' "Comprehensive Mental Health Plans" prepared during 1963-65 recommended that increased numbers of licensed practical nurses be recruited for nursing services in state psychiatric hospitals, psychiatric units of general hospitals, and facilities for the mentally retarded and aged. Several of these also urged that basic instruction in mental health and psychiatric nursing be included in practical nurse education programs.

The salaries reported for licensed practical nurses in state hospitals in the Southeast range from a minimum of $15 to a maximum of $63 per month above that of the on-the-job trained attendant or aide. One hospital superintendent reports that the salary for licensed practical nurses employed by the state hospital is approximately $40 per month more than that paid them by general hospitals in the area.

A variety of training programs designed to prepare practical nurses to function effectively in mental health and psychiatric nursing services have been developed since 1950. Most of them have been established as demonstrations or special programs in response to local demand.

*The SREB was established in 1948 by interstate compact as a public agency of member states cooperating to improve higher education. The mental health training and research program, established in 1955 on recommendation of the governors of participating states, works with state mental health program directors to improve training and increase recruitment of personnel in all mental health agencies.

Reports of several of these programs and recent developments in national mental health program planning, as well as a recommendation from licensed practical nurses illustrate awareness of the need for and increasing interest in this training.

The Minnesota Department of Public Welfare, supported by a five-year (1956-62) pilot training and evaluation grant from the National Institute of Mental Health, conducted a training program to prepare practical psychiatric nurses.* The performance of these nurses in both psychiatric and general nursing has been excellent. Recruitment potential is suggested by the report that no student withdrew from the program because of a dislike of psychiatric nursing.

A practical nurse school in Florida includes one month of clinical practice and instruction in the psychiatric unit of a county hospital. This hospital and a state psychiatric hospital in the community employ a number of the licensed practical nurses who graduate from this school.

Two state hospitals in Virginia provide a six-month orientation and inservice training program for licensed practical nurses interested in working in the state's mental health program. Classified positions with promotion opportunities and merit salary increases are available to these nurses—in all Virginia state hospitals—upon completion of the training.

Many licensed practical nurses have enrolled in extension courses, in "post-graduate" courses, and in the inservice training programs of psychiatric hospitals and psychiatric units of general hospitals. Others have attended all available mental health and psychiatric nursing workshops.

The Council of State Governments' publication, *Action in the States in the Fields of Mental Health, Mental Retardation and Related Areas* (1966), reported that several states are either providing affiliation in psychiatric nursing for practical nurse students, or are negotiating arrangements for psychiatric aides and technicians to complete qualifications for practical nurse licensure.

The House of Delegates of the National Federation of Licensed Practical Nurses adopted a resolution in 1965 asking that mental health and psychiatric nursing be included in the basic curriculum of all schools.

These and other reports of need and interest prompted an enquiry to directors of state departments of vocational education to determine whether professional nurses teaching in schools of practical nursing would be interested in attending a clinical workshop in mental health and psychiatric nursing during the summer of 1966. Response to this enquiry indicated that as many as 200 nurses in the Southeastern states would be interested. It seemed clear that a clinical workshop in mental health and psychiatric nursing for educators in schools of practical nursing in the South might serve two purposes:

Improvement in the quality of instruction in mental health and psychiatric nursing in practical nurse schools, and

An increase in the number of practical nurse schools providing this instruction in the basic curriculum.

Evidences of the extent to which these purposes were achieved are suggested by the content of this report.

*Practical Psychiatric Nursing—Report of a Pilot Training and Evaluation Project for Psychiatric Aides.

THE PLAN

A regional committee assisted the SREB mental health unit staff with the planning.

Objectives

To instruct teachers of practical nurse students with recent developments in knowledge, attitudes, and skills in psychiatric nursing.

To develop education objectives, curriculum, instruction materials, and procedures for use in teaching mental health and psychiatric nursing to practical nurse students.

Trainees

Directors and instructors in schools of practical nursing from the states participating in the SREB mental health training and research program.

Faculty

Three specialists in psychiatric-mental health nursing and three clinical instructors served as full-time faculty. Professional staff members of Western State Hospital and DeJarnette Sanitarium also participated in the teaching.

Procedure

Trainees were assigned supervised clinical practice with patients; attended and participated in lecture discussion sessions and treatment program activities; worked with instructors to develop objectives, content, methods and materials they might use for practical nurse instruction; developed plans for identifying and organizing clinical experiences for instruction of students; and planned workshops and activities to assist instructors in their states to update their knowledge and skill.

Five months following the workshop, trainees reassembled for a follow-up conference. They reviewed the problems encountered in implementing workshop plans, identified needs and resources and made recommendations for further action.

A follow-up workshop for all practical nurse instructors in each state was recommended.

THE WORKSHOP

Setting

Western State Hospital, Staunton, Virginia, was selected as the principal clinical facility for the workshop. This hospital employs a number of licensed practical nurses in the nursing services. Work roles are well defined, job descriptions are written, and available to applicants for positions. Trainees were therefore able to observe the work of licensed practical nurses in psychiatric nursing services. DeJarnette Sanitarium, a private psychiatric hospital adjacent to the state hospital, also provided opportunities for trainees to observe and participate in group activities of patients

which were not included in patient care services at Western State.

Recruitment and Selection of Trainees

An abstract of the workshop plan, with an invitation to nominate two applicants, was sent to the director of vocational education in the state department of education in each of the fifteen states participating in the SREB mental health training and research program. Fourteen states nominated applicants. Thirty nurses from thirteen states in the region attended.

Faculty Orientation and Organization

The project director spent more than a week, and other members of the faculty spent three days, at the hospital preceding the workshop. They met patients and staff; became acquainted with the treatment program, the hospital policies and procedures; and oriented hospital staff members of clinical units to which trainees were assigned and staff members who participated in the teaching to the workshop plan.

A mental health and psychiatric nurse specialist and a clinical instructor were assigned to teach and supervise ten students. The project director attended and participated in all faculty meetings and general sessions, observed group sessions, and served as liaison to hospital staff and faculty. The training and research director of the hospital served on the advisory committee and worked closely with the workshop faculty throughout the period.

Content, Methods and Results

The NLN Achievement Test in Psychiatric Nursing was administered at the initial assembly. More than a third of the trainees had no previous basic instruction in psychiatric nursing. The basic preparation of more than half of the others had been received 15 to 25 years previously. Members of the faculty felt that some appraisal of trainees' current knowledge in mental health and psychiatric nursing theory and practice, such as that which the test might provide, would help individuals and faculty assess needs and plan content and learning experiences necessary to accomplish project goals.

The initial percentile rank of the trainees who had basic psychiatric nursing during the past 15 years and those who were teaching in schools currently providing instruction in mental health and psychiatric nursing were higher than that of those who had no basic instruction or had had it earlier. The test was repeated the last day of the workshop. Al trainees except one (whose initial score was well above the class median and remained the same) made substantial gains in percentile rank. Examples of change: 04 to 23, 05 to 32, 14 to 77, 19 to 61, 41 to 96, 79 to 98. The increase in the median percentile rank for the group was 30.

Following the NLN test period, members of the hospital's administrative staff met with faculty and trainees and described the philosophy and treatment services. Staff members from units selected for clinical assignments also attended. They were invited to attend all general assemblies in which they were interested.

During the afternoon of the first day, faculty and trainees toured clinical units and reviewed the clinical assignments which had been selected. They also discussed the list of other activities, such as field trips, available to them on an elective basis and made selections according to their interests. Trainees were given a packet of basic reference and study materials, including books, reprints, pamphlets, a film list and bibliography. This assured each trainee immediate access to reference materials, eliminating the necessity of locating the hospital library in a new setting. A number of these materials were inexpensive publications from public service and governmental agencies, or complimentary from mental health associations, foundations, and pharmaceutical companies, sources not previously known to all

trainees. They said that immediate access to reference materials for personal use during the workshop facilitated study, and expressed special appreciation of the opportunity to review and discuss with faculty members the use of these basic reference materials in their teaching.

Participation in the nursing service activities which included interactions with individual patients and process recording of these experiences, attendance at remotivation sessions, psycho-drama, semantics classes, occupational and recreational activities gave trainees opportunities for sampling learning experiences available for students as well as insight into the goals, accomplishments and limits of current mental health services.

The interaction notes describing their experiences with patients were reviewed in conferences with faculty members who also discussed use of this tool in teaching students. Attendance at diagnostic and treatment planning staff conferences gave trainees an opportunity to assess the potential of this experience for integrating the work of the ward staff in the care of the patient. Professional staff members of the hospital led lecture discussions which included Personality Growth and Development, Trends in Mental Health Programs and Services, Current Concepts of Treatment, Drugs in Psychiatric Treatment, and Treatment of Alcoholism. These discussions provided opportunities to extend trainees' knowledge of mental illness, its effect on individuals and families, and to acquire knowledge of current treatment and services.

Trainees and faculty attended the movie, *Who's Afraid of Virginia Woolf*. The mental health aspects of the characters were discussed in conference with a psychiatrist. Two additional films, *The Nurse-Patient Relationship* and *The 91st Day*, were reviewed and their value for teaching students assessed.

A brief description of the training activities and rehabilitation program of the Woodrow Wilson Rehabilitation Center, a regional facility near the state hospital, was presented during a tour of the Center.

One or more licensed practical nurses employed at the hospital were interviewed about their work by individuals or groups of trainees. A guest lecturer from the National League for Nursing discussed the work of the NLN Department of Practical Nurse Education. The American Nurses Association staff member who is liaison to the National Federation for Licensed Practical Nurses discussed the interest in psychiatric nursing education and service being expressed by members of the Federation.

Each group selected the type and format for the instructional materials and began preparing them to use in their programs during the workshop. They developed course objectives and discussed procedures for introducing, expanding and improving mental health and psychiatric nursing instruction in practical nurse education.

A narrative-type daily work sheet prepared by trainees with the content categorized under *What I Learned Today*, *How I Plan To Use*, and *Questions I Have*, helped faculty and trainees search out and use opportunities for learning. In these daily reports, trainees said their experiences and instruction were useful to them to update knowledge of psychiatry and psychiatric nursing; clarify misconceptions about the mentally ill; broaden concepts and skills in teaching by learning the use of interaction notes; enhance sensitivity through informal group conferences focused on feelings; and make effective use of mental health films and other reference materials.

Throughout the workshop period, faculty-trainee group and individual conferences were used in preparatory and follow-up exploration and teaching of psychiatric nursing concepts and skills.

The date and plan for a follow-up conference, (held at the end of the first school semester following the workshop), was established.

Trainees submitted progress reports describing the activities they had initiated or participated in following the workshop one month before the follow-up conference. Individuals had assumed leadership in continuing curriculum review and revision with groups of instructors, established planned field trips to psychiatric facilities, and assisted with planning extension courses in mental health and psychiatric nursing for licensed practical nurses. Statewide workshops or institutes to prepare teachers in practical nurse schools to upgrade and expand mental health and psychiatric nursing in practical nurse education programs had either been planned or scheduled in nine states.

During the follow-up conference, faculty and trainees reviewed problems encountered in implementing their plans, discussed the resources they had identified, and prepared recommendations for future action. State supervisors attended the conference and evaluated the achievements of trainees.

TRAINEE PROGRESS REPORTS

The following statements from progress reports submitted to faculty in December, 1966, suggest the extent to which trainees appear to have achieved objectives and incorporated learning experiences into their teaching, curriculum planning, identification and use of resources:

For the first time, I am using nursing home facilities for practical nursing experiences.

I am emphasizing that the nurse-patient relationship is the core of good nursing practice.

Interaction notes prepared by students are being used to guide them in assessing patient needs and to gain more insight into their behavior.

I have used the knowledge and materials from the workshop to help practical nursing instructors gain an understanding of current practices and goals of psychiatric nursing.

We are in the process of beginning a psychiatric aide class in cooperation with the Welfare Department and the material has been very valuable in developing this program.

The faculty has been meeting weekly since my return from the workshop. We are revising the entire curriculum to utilize mental health concepts throughout the program.

A workshop is being planned to inform other faculties in the state.

We are not presently teaching mental and psychiatric nursing as a separated entity, but are broadening and reinforcing these concepts in our present curriculum. Students are being assigned to nurse alcoholics and depressed and excited medical and surgical patients.

Special attention is being given to major mental illnesses late in the one-year program. The psychiatric social worker is giving some lectures.

I reported the workshop experience to faculty, emphasizing objectives and plans. I have visited the state hospital, the office of the Mental Health Association, and the psychiatric unit at the General Hospital. We are working on plans to incorporate psychiatric experience in our practical nursing program.

I gave a report on the workshop at the Health

Occupation Section meeting of the State Industrial Education Association Convention.

I have visited approximately one-half of the vocational nursing programs in our state since the workshop. We have discussed the need for including psychiatric nursing concepts into the basic curriculum, and made recommendations to expedite accomplishment of this.

Time has been scheduled for the two participants from our state to discuss the workshop and the follow-up conference during our teacher training workshop. We will attempt to develop a technique for augmenting mental health concepts, as a curriculum requirement, into all vocational nursing programs.

Faculty members are working on course outlines. We have made a list of concepts and are attempting to fit them into each of the clinical courses and all of the basic nursing procedures.

What I learned about mental mechanisms and how they work is being used to help students gain a better understanding of themselves and their patients.

I am more aware of *all* needs of the patients and am using every opportunity to teach these to my students, and to relate the patient's needs to psychiatric nursing concepts. I am planning to revise my course in mental health to incorporate more psychiatric nursing concepts, and to make assignments more meaningful in the clinical areas by conferences with students about these experiences.

Brief interaction notes are written daily by students. Students are identifying needs with greater speed and understanding. Opportunity is provided each student to discuss their notes in a post conference session.

Our vocational education department has cosponsored a workshop on interpersonal relations with the State League for Nursing.

I am encouraging practical nurse students to take advantage of the six-week planned program in psychiatric nursing now being offered on an elective basis at a state hospital.

I am working with vocational educators in home economics service to emphasize the importance of teaching mental health concepts early in the student experience.

I am utilizing new knowledge in developing, with practical nurse teachers, plans to integrate psychiatric nursing into the curriculum and to evaluate one-day field trip to a state mental hospital which is planned for most practical nursing students.

I have had several meetings with instructors in this area. We are working on the number of hours, as well as content, to include in the psychiatric nursing course.

We are planning to have a field trip to a state hospital and to include some patient and student interaction if possible.

I am developing materials in the techniques of role-playing situations that require use of psychiatric concepts.

I am developing an instructor's guide for integrating psychiatric nursing in a geriatric setting.

We are requesting approval to conduct a one-week workshop for vocational nursing instructors during the summer months. The purpose of this workshop will be to review and update knowledge of psychiatric nursing for more effective teaching.

An extension course for LPN's in our area has been organized. It includes thirty (30) hours of theory and thirty (30) hours of supervised practice at a psychiatric hospital.

A review of the plan and content of the workshop was given to our recent workshop for all school faculties.

I sent letters to the Assistant Superintendent of Vocational Education, Director of Trade and Distributive Education and Director of Lafayette Area Vocational and Technical School, summarizing objectives of the workshop and the benefits derived both present and for the future.

I gave a report of the workshop to the Supervisor of Health Occupations. We discussed the need for a similar workshop for all instructors in our state. In September, approval was given to design a grant proposal to submit to the U.S. Office of Education. While planning the workshop, various meetings were held with the staff of the Department of Mental Health. As a result of these meetings, plans are underway to utilize facilities of another

state psychiatric institution for clinical experience of students in two practical nursing schools. When these plans are completed, all of the practical nursing schools under Vocational Education will have psychiatric nursing, both theory and clinical experience, as a block in the curriculum.

I am revising the content of the psychiatric nursing course.

I am selecting patients with exaggerated emotional problems for student clinical assignment. Each student writes a report of her observations and conversation. Students are divided into groups of four to read and discuss these reports. Problems are identified and studied in a follow-up discussion period.

In each subject, I find that more practical understanding and learning takes place when certain basic concepts are utilized and explained in simple terms. Example:

Procedure: Enema
Concept: The patient is a human being who needs to be respected as a person.
Application: Maintain privacy
Explain procedure
Inspire confidence

Promotion of self-awareness in the student is begun by having group interaction sessions on topics which will lead to recognition of basic needs and drives experienced by all persons in attempting to adjust to the demands of everyday living. As students are able to recognize their own feelings in these sessions, patient situations are introduced to develop understanding of how a patient might feel, and therefore, respond in a particular manner. Skills in observation and communication are introduced and developed to understand interactions and develop nursing care plans. Related patient situations which might occur in the general hospital setting are discussed and nursing approaches developed on the basis of understanding individual needs. This method enables the student to transfer the broader concepts of psychiatric nursing she is learning into her experiences with patients on any service.

On return from the workshop I learned that the hospital was beginning to utilize group therapy and team conferences. This has given me another area for student experience (with special guidance and assistance of the Clinical Director—Intensive Treatment).

I have developed a questionnaire for student evaluation to emphasize the effectiveness and necessity of this type of experience for the practical nurse student, no matter where she plans to work on completion of her training. After the results have been tabulated, I will make copies to present to instructors in the state who may not have this type affiliation as a part of their curriculum.

FOLLOW-UP CONFERENCE

Progress reports and samples of instructional materials trainees had prepared were sent to faculty members for review and evaluation before the follow-up conference convened. Members of the faculty met preceding the opening session and identified the objectives of the follow-up conference:

- To review problems encountered in attempting to implement workshop plans.
- To determine specific additional needs to assist conferees to implement plans.
- To identify resources to expedite implementation.

- To consider whether participants wished to formulate recommendations which would extend or expand the effectiveness of the experience.

At the opening session, Miss Helen Powers, Director, Vocational and Technical Health Occupations Training, USOE, and Dr. Harold L. McPheeters, Associate Director for Mental Health, SREB, discussed "Meeting Mental Health Service Needs—Implications for Technical and Vocational Education." Dr. McPheeters also reviewed "Trends in Mental Health Programs and Services."

Faculty and trainees reviewed and further refined instructional materials. They also discussed problems they had encountered, the needs which they considered crucial to realizing their objectives, listed the resources they had identified, and made some recommendations for continuing and future action.

Problems

- Lack of funds to support workshops and maintenance of students assigned to psychiatric nursing experience in an affiliating agency.
- Locating substitute teachers for instructors to attend workshops.
- Clinical areas unavailable for psychiatric learning experience.
- Planned programs for post-graduate education in psychiatric nursing for licensed practical nurses available.
- Inadequate use of administrative channels for communication.
- Service personnel uninterested or failing to recognize the needs of students for support and incidental instruction "on the spot."
- Clinical experiences may be traumatic to students if they fail to see patients progress.
- Indirect resistance to integrating mental health concepts into all courses from faculty members: "We are already doing this."
- Effective work with professional staff members in clinical settings so they will let students express feelings as they learn.
- Handling feelings of rejection and anxiety of instructors.
- Teaching students patient-centered nursing in a functionally oriented nursing service. Example of assignment: "I have the beds on this end of the ward."

Needs

- To identify the facilities available and to develop plans to use these for learning experiences in psychiatric nursing for students.
- Continuing help to instructors in integrating mental health concepts in classroom and clinical settings.

Resources

- Faculty and workshop participants, mental health agency staff, hospital staff, Chambers of Commerce.
- Educational institutions—specialized faculty members.
- Funds for workshops and continuing education:
  - Vocational education agencies
  - U.S. Public Health Service
  - National Institute of Mental Health
  - Manpower Training Development Act
  - Local foundations
  - Professional organizations
  - Voluntary mental health and mental retardation organizations
  - Jaycees
- State Boards of Nursing
- Materials, foundations, publishers and pharmaceutical companies.

Recommendations

A number of the recommendations made by participants were essentially addressed to themselves—reminders of the potential they

developed during the experiences stimulated by the project.

- Teach mental health and psychiatric nursing concepts in all practical nurse programs.
- Ask psychiatric nurse leaders and other mental health professionals in the community to assist with curriculum planning.
- Plan and structure field trips to local mental health agencies to insure positive outcomes and desirable learning.
- Make effective use of literature, films, and teaching aids available through mental health agencies. Identify mental health services available within the community.
- Workshop participants initiate planning a series of workshops to upgrade knowledge and ability of all instructors in the state to teach mental health concepts. Invite professional and practical nurse organizations to join in sponsorship and planning.
- Seek vocational education agency interest and support for inservice education to update psychiatric nursing knowledge for nursing service staff members in areas to which students are assigned.
- A list of postgraduate programs in psychiatric nursing for licensed practical nurses should be available to students.
- Employment opportunities for licensed practical nurses in psychiatric nursing services should be encouraged and students should be informed of these.
- Plan regularly scheduled continuing education for instructors in practical nurse education programs to keep knowledge and skill current.
- Plan an additional follow-up session for this workshop in about a year to further evaluate success in implementing the projects which have been initiated.

EVALUATION

Comments by state supervisors and observers attending the follow-up conference:

> I detected evidence that some trainees have experienced resistance to change—co-workers have not moved as fast as trainees hoped they would during this first semester since the workshop. Several expressed concern about support to implement state workshops. It will be particularly important for them to avoid assuming that others understand what they hope to achieve. There is a difference between specialist practice and practice of mental health concepts and principles in all work with troubled people. Instructors need to continually enhance their own experience and background to keep abreast of new developments. I believe workshop participants are aware of this.
>
> I was struck by the evidence that participants had worked together and were prepared to begin their work in the follow-up conference 'where we left off in August.' Obviously they shared common goals—although they had approached their work in applying the knowledge gained and the materials prepared in different ways. I was amazed at the accomplishments of individuals on their own since the workshop and consider this to be a demonstration of what happens when there is a combination of quality faculty and trainee commitment to goals.
>
> One result of the workshop seems to have been that of providing opportunities for state supervisors of practical nurse education and state mental health and psychiatric nurse consultants to become more aware of each other and of the potential of working to-

gether. In one state, the psychiatric nurse consultant and state supervisor of practical nurse education have resolved to get the Commissioners of Education and Mental Health together to investigate opportunities for continuing education which we can use together. The work groups demonstrated excellent examples of conference teaching. I suggest that trainees continue communication through sharing information about specific activities, or about articles they read.

The *volume of work* done by trainees in three areas should be emphasized—teaching teachers, teaching students, and involving people who must be involved to get mental health and psychiatric nursing instruction in practical nurse education.

I was impressed with the freedom of the discussion and the sharing of ideas and materials. These groups are a corps of united workers who have investigated and understand the need, who are trying out ideas to educate and lead within their states. They are thinking big.

Both the materials produced by trainees and the character of the interaction among group members are evidence of the dynamic leadership of the faculty as well as the industry and interest of participants. Two state universities are offering workshops with credit next summer to provide opportunity for additional nurses to have a similar experience.

This group accomplished more in two weeks than many workshops do in four. I was impressed that groups had considered what trainees would be expected to do when they returned to their work. Some will encounter resistance in other faculty members, so these expectations and plans will help them to deal with this resistance.

In our state, we have already sent a memo to the State Department of Education requesting funds for a similar workshop for all instructors.

Comment on the impact of the workshop on training and assignment of licensed practical nurses at Western State Hospital:

A state supervisor asked Dr. Grey if the hospital had made any changes in the inservice training and work assignments of LPN's as a result of the workshop.

Dr. Grey said that supervisors on units to which trainees were assigned during the workshop had been interviewed. They said they had learned some things about the education and work expectations of LPN's which is helpful in providing support, guidance, and instruction to LPN staff members.

CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS

The integration of mental health and psychiatric nursing concepts into the curriculum and the inclusion of planned clinical instruction in practical nurse education were the goals which underlay the objectives and program plan. All trainees did not come to the workshop committed to the notion that they would, as a consequence of the experience, return to their states and find ways to do so, although most of them were aware of increasing employment opportunities for licensed practical nurses in mental health services.

Several trainees whose basic clinical instruction had been a traumatic experience in a custodial care setting even expressed some initial anxiety about the clinical assignments in the workshop schedule. However, significant changes in the treatment of psychiatric patients have made patients more optimistic and nursing's work with them more rewarding. Many of the trainees were amazed and delighted to see patients behaving responsibly, accessible to counseling, interested in knowing as much as possible about their medication and treatment regime, and assuming responsibility for planning and participating in therapeutic activities. They were convinced that changes in patient outlook and expectations were both a challenge and incentive to nurses in psychiatric services.

The more optimistic outlook for patients, the opportunity to work with and observe licensed practical nurses in the nursing services of the hospital, and the participation of two trainees who were teaching psychiatric nursing to practical nurse students seemed to contribute to a general agreement that mental health and psychiatric nursing instruction should be included in practical nurse education. Several trainees expressed a firm commitment to the belief that a clinical learning experience can and should be included in the curriculum. Others leaned toward a belief that this can be done by integrating the concepts throughout the curriculum, and by adding postgraduate and extension courses.

The two-week clinical workshop was held in August (1966) and planned to involve participants in this educational venture fairly close to the beginning of a new school term. The dates for the follow-up conference, established at the close of the workshop, and held at the end of the fall semester (January 1967) was timed to allow participants opportunities to assess progress toward achievement of objectives and plans for using the workshop experience. The content of their progress reports and the sample instructional materials they prepared and tested during the fall semester attest to the productivity and usefulness of the plan.

Trainees commented on the motivational factor stimulated by the NLN Achievement Test being given at the beginning of the workshop and repeated the last day.

Several acknowledged during or following the workshop that they had expected faculty to ask them to do some pre-workshop reading and prepare materials to bring with them. Members of the planning committee and faculty had considered this, but believed that to do so might result in group members becoming preoccupied with the materials they had brought, and thus limit the inquisitiveness and creativity stimulated by a fresh experience.

For half a century, hospital schools of nursing prepared registered nurses without teaching them psychiatric nursing. There was little pressure and only occasional expressions of need for nurses having basic preparation in nursing psychiatric patients from mental hospital administrators. Registered nurses found ready employment in general hospitals and other facilities not serving psychiatric patients. Now the demand by mental health program administrators for professional psychiatric nurses and for licensed practical nurses, who have basic knowledge and skill in psychiatric nursing, far exceeds the number who are qualified. It seems clear that nurse educators must take seriously this demand. This workshop has obviously generated interest and charted a course—but it is only a beginning. These nurse educators have set themselves tasks which they can accomplish only if there is interest, support, and active collaboration from mental health agency personnel and nursing organizations, as well as administrators and educators in vocational education.

Trainees, faculty and members of the planning committee have recommended that administrators of mental health agencies and vocational education programs establish commu-

nication which will:

- Assure instructors of practical nurses of their willingness to support and assist with instruction in mental health and psychiatric nursing in practical nurse education.
- Provide continuing information about employment opportunities for licensed practical nurses in their facilities.
- Provide assistance with educational programs to update the preparation of instructors of practical nurses in mental health and psychiatric nursing.
- Assure employment of consultants and faculty to plan appropriate content and teach mental health and psychiatric nursing to practical nurse students.

SUMMARY

Thirty-one professional nurse educators in schools of practical nursing in the Southeast attended a two-week clinical workshop in psychiatric nursing at Western State Hospital, Staunton, Virginia, in August 1966. They reconvened for a three-day follow-up conference in Atlanta, Georgia, in January 1967. These activities were supported by a grant from the U.S. Office of Education and co-sponsored by the Southern Regional Education Board, the Virginia Department of Mental Hygiene and Hospitals and the Western State Hospital, Staunton, Virginia.

The project had as its objectives updating the knowledge and skill in mental health and psychiatric nursing of instructors in practical nurse schools, and the development of education objectives, curriculum, instruction materials and procedures for teaching mental health and psychiatric nursing in practical nurse schools.

A project director, three mental health-psychiatric nurse specialists, three clinical nursing instructors, professional staff members from Western State Hospital and DeJarnette Sanitarium served as faculty.

Trainees attended and participated in staff conferences, had assigned clinical practice with patients, group and individual instruction in mental health and psychiatric nursing knowledge and skills, attended lecture discussion sessions and went on one field trip.

They prepared instructional materials, considered and began implementing plans and procedures for integrating mental health and psychiatric nursing content in the curriculum during the workshop.

During the follow-up conference, faculty and trainees reviewed the progress made in implementing workshop goals, discussed and further refined the instructional materials which had been prepared and tested during the fall semester, identified problems encountered in planning and implementing objectives in state programs, and made recommendations for further action.

Nine states have either held or scheduled follow-up workshops.

APPENDIX A

PERSONAL, EDUCATIONAL AND PROFESSIONAL CHARACTERISTICS OF TRAINEES

Age Range		Marital Status	
Under 30	3	Married	18
30 – 40	7	Single	7
42 – 49	15	Widows	3
51 – 55	6	Divorced	6

Nursing Education

Graduates of Diploma Programs	—	29
Graduates of Basic Degree Programs	—	2
Credits toward B.S. or B.A. Degree	—	12
Credits toward M.S. Degree	—	11
Master's Degree	—	6

Basic Psychiatric Nursing

Basic preparation in Psychiatric Nursing	—	19
No basic preparation in Psychiatric Nursing	—	12

Behavorial Science Background

Psychology and Sociology	—	24

7 did not list the above courses

Professional Experience

There was a wide range of professional experiences. The largest number of participants had experience in general duty or head nursing on a medical-surgical unit. The following areas were also listed: psychiatric nursing, operating room, maternal and infant nursing, and nursing of children. Further listing of experiences included: school nursing, office nursing, mental retardation, public health, inservice-education, educational consultation and coordinator or practical nursing education.

APPENDIX B

EXAMPLES OF DAILY SCHEDULE

Time	Activity	Groups I	II	III
Wednesday, August 17, 1966				
a.m.				
8–9:00	Group Conferences	X	X	X
9–10:00	Clinical Assignments	X	X	X
10–11:00	Diagnostic Staff Conference			X
10–11:00	Patient Government Conference	X		
p.m.				
12–1:00	Lunch	X	X	X
1–3:00	"Basic Psychiatric Concepts, Symptoms and Syndromes" —Dr. Grey	X	X	X
3:15	Faculty Meeting			
5:30	Trainees' Recreation With Patients			
Friday, August 19, 1966				
a.m.				
8–9:30	General Assembly (Weekend Assignments)	X	X	X
9:30–11:00	Clinical Assignments	X	X	X
11–12:00	Film — "Nurse-Patient Relationships" — Discussion	X	X	X
p.m.				
12–1:00	Lunch	X	X	X
1–3:00	"Current Concepts of Psychiatric Treatment" —Dr. Lyon	X	X	X
3–4:30	Individual Conferences With Faculty			

APPENDIX C

CONTENT OF DAILY WORK SHEETS

TRAINEE A

What I've Learned:

I learned through taking the League test the areas in which I need to study (chemotherapy), and that I haven't forgotten as much in psychiatric nursing as I feared I had in other aspects.

I learned that this hospital has some valuable objectives while at the same time recognizing its limitations, and that makes me like and appreciate such a philosophy very much.

The four stages of personality development—concepts of personality, self and personal world and their interrelationships.

Physical environment of ward. Introduction to staff.

I have seen that patients behave the way they are expected to behave.

I learned that meaningful communication is a skill that takes much practice.

Patients are able to direct their own behavior as a group.

The ways in which the patient has contacts and activities outside the hospital such as bowling and church.

Concentration of large number of psychiatrists in private practice and great need for them in state hospitals.

Future plans for expansion of mental health facilities.

I have an excellent overall view of the drug therapy and its use based on the two approaches to psychiatry (biochemical and psychosocial). I better understand the composition, indications and side effects of these drugs.

I learned why the patient is awake for shock therapy. I also learned that the shock treatment is just as I observed it 22 years ago. No change in procedure or nursing care.

I had a good review of alcoholism. Most was familiar to me.

Today was very stimulating. I had semantics and ward meeting as well as staff meeting and a film. In staff, Dr. R. tied together everything I've seen and heard in the workshop. In semantics class I gained some insight into the feelings of these patients. In ward meeting, I observed again how well organized and cooperative the group was. I thought this ward meeting, led by a nurse, was much more therapeutic than the one led by the O.T. person. I had not seen the movie before and I found it to be excellent in portraying the precipitating factors and onset of mental illness.

I learned a great deal about many newer aspects of psychiatric therapy—such as patient government, remotivation, chemotherapy. I developed a better understanding of the milieu of the mental hospital today. Of all the enriching experiences, I feel I benefited most from the readmission staff conference on A.3 and the ward meeting on A.5. These gave me an opportunity to appreciate the improvement in patient behavior resulting from drugs and group therapy. Perhaps it takes someone who has no contact whatever with a state hospital for 22 years to really appreciate the change.

I feel the employees I encountered—from the attendants to the director—had a sincere interest in the patients and this communicated itself to others.

The workshop as a whole was extremely beneficial. It met all my needs as an instructor with little recent experience in this field. I feel much better qualified to speak now on the current trends.

The faculty for our group were experts at directing our experiences and offering assistance. They helped direct our thinking and clarified for me anything that wasn't entirely clear.

In the past, I felt frustrated because I had no psychiatric facilities available. Now I am enthusiastic and also more aware of the many opportunities available in a general hospital.

Ways I Can Use:

I am in between jobs—no longer teaching, but not yet on the new job as a state region supervisor of health occupations training. I do have a program of psychiatric affiliation for student practical nurses included in my region, but I am not yet familiar with its setup or needs. I am trying to absorb everything, therefore, as I don't know my specific uses for the material. Follow-up workshops will be very beneficial as I then will know the programs better in my area.

Programmed instruction to be prepared on this personality material for presentation to students.

I can present the student what I have seen and witnessed as evidence that psychiatric nursing concepts are valid.

I think that practice in communication will help in counseling students that have emotional problems.

Students and employees also will behave as they are expected to behave (assumed but not demonstrated before).

I can structure behavior patterns through expectations.

Bring up in class discussion with my students.

I can impart this knowledge to other instructors.

I do not know yet how I will use much of this material. It will take time to assimilate it. I feel I have learned much more than is indicated, but it is still "fermenting."

Questions I Have:

To what extent are locked wards still necessary?

What is the average length of stay in a hospital?

Do you have many return patients readmitted after previous discharge?

TRAINEE B

What I've Learned:

That I have many gaps in memory and in experience in psychiatric nursing knowledge.

The long- and short-range goals of Western State Hospital.

The functions in education of SREB.

The need of trained personnel in psychiatric nursing and the LPN's role.

There are still too few, for too many, for too long.

The need for clearly defined roles for nursing personnel.

A new appreciation of the self-concept in relation to "environment."

The same "face" of the patient who has been institutionalized a long time.

To work harder in mental hygiene.

Some answers to the "Virginia Woolf" riddles.

Basic psychiatry.

That vocational instructors in practical nursing are a sturdy group.

More about the professional staff members of Western State and their goals.

That I did interact with a patient although I ended up feeling he was trying to help me with the meeting.

Group thinking and discussion helped to focus on areas of intervention, although still very general.

Drug therapy lecture was most informative and enjoyable. Dr. Hanson is excellent in the teaching capacity.

Alcoholism frightens many people (besides me). I am again distressed by the minor effort, comparatively, that is acknowledged to be in progress with high school students, while the number who are drinking regularly increases.

We reviewed individually and in the group what we have so far derived from this workshop and made some plans for development of psychiatric concepts in the LPN program.

I have learned during the past two weeks, primarily, the need to reinforce the "whole patient" care premise throughout the LPN program beginning with the student, then emphasize the patient's needs in the areas of behavior changes such as pre-operative anxiety, or patient-family-nurse interaction—when the patient is a child—first baby—new mother fears—father wearing out the carpet, too often left out literally. This learning can be capsuled in one word—*direction*. Direction toward the whole person's concept of body and mind and how this premise could enrich the LPN program.

Ways I Can Use:

Fill the gaps.

Application of similar goals in our school.

Use of TV as an instruction media.

Basic preparation needed for students to enter this field.

Ways of reducing mental illness—community services, treatment, etc.

Practice writing a realistic role for the practical nurse in psychiatric nursing.

Additional understandings will, I hope, permit better presentation to students.

All will enhance understanding—particularly that of integrated curriculum.

One interview may be helpful to others.

Develop technique of listening, then try to add up.

From the group, to better individual focus.

Additional knowledge.

Community effort, to students, many of whom are able to bring their learnings home to families.

I hope to use a steady stream of student "self" —patient "self" principles based on understanding and acceptance with support in proportion to need.

There will be a need to modify terminology for best comprehension.

Role playing will be a tool to see and feel these situations better.

Student will be encouraged to write interaction notes, see her feelings relating to patients, co-workers, etc.

Faculty awareness of needs for human communications will foster many learning and developing opportunities.

This can be a core to radiate from one to another personnel.

I see a need to modify terminology, use role playing in simple situations, have student write out feelings.

Patient-study with guidance to see patient needs and learn to meet them.

Faculty continue studying and reading to reinforce each student's experience.

Avail ourselves of opportunities to involve other personnel in projects.

Use guest lecturers from mental health disciplines as resource people.

Community learning experiences: kindergarten, retarded children, geriatrics, family experiences (children, husband), public health visits to homes-high schools.

Questions I Have:

How do admissions compare with ten years ago as to ages, stay, diagnosis, recurrence?

Will we be able to explore methods of instruction?

What purpose was served in showing this film to the lay public? (Virginia Woolf)

Would the community or some resource of it, such as church women, be interested in the "take a room project?"

Will the basic teaching in LPN schools be of value if a postgraduate course is presented as it is planned here?

Will I be able to interact? Tomorrow will tell the tale.

Will we get these papers back with comments that will help redirect?

Questions I have are being answered during sessions and by reference reading.

In a loss to families and communities, is the main cause psychogenic, physiological or both?

Questions I have, I'll send them to you (faculty member) as they surely will come with my efforts this fall and winter.

Questions I have will be referred to advisors if I cannot find a solution.

APPENDIX D

SAMPLE INSTRUCTIONAL MATERIALS

The following examples will suggest instructional methods the teacher can use to teach students psychiatric nursing concepts and the application of these concepts in caring for all patients.

ROLE PLAYING IN CLASS OR CLINICAL CONFERENCE

(a) **Concept**

All behavior has purpose

Situation

The student is on duty on this unit for the first time. In checking her assignments, another LPN remarks, "I feel sorry for you!," pointing to this particular patient's name. "I sure am glad our instructor assigned her to you. We have been waiting for the new students to come since this patient has been dealing us fits all week. That patient just absolutely will not cooperate. She thinks we are all stupid and will not let us do a thing for her. I told her if I did not know what I was doing, I would not be here. She said she got the wrong medicine one time. The very idea of some people! Nurses don't make mistakes. If you need any help, don't call me!"

The student checks with the head nurse and is told, "Do what you can for Mrs. F. We have all leaned over backwards trying to please her and cannot do anything with her. She thinks she knows it all and that we do not know anything. I have threatened to take the doctor's orders in just to show her. The doctor says do the best we can. She is on a low sodium diet, on complete bedrest, but insists on getting up to the bathroom, intake and output, has a Foley catheter which is to be irrigated every day at 9 a.m. with normal saline. Mrs. F. has been here a month and still hasn't adjusted."

In checking the chart, the student finds such remarks as these on the nurses' notes: patient refuses medication, out of bed to bathroom, does not cooperate, wants someone to stay with her, questions everything, cried for an hour after her Foley irrigation, refuses to eat, refuses to talk to anyone.

The student relates the nursing care she gave to this patient. "I wasn't able to do very much. I was so scared when I met the patient. You know all those things the staff said about her were true. She started firing questions at me; then said I couldn't know much since I was only a student. I didn't know anything by this time. I'm beginning to wonder why I ever wanted to be a nurse. I didn't do any nursing care. Please don't assign me any more patients like her."

Analyzing the Patient's Needs

At this time the student needs help in learning to understand her own feelings. Only by understanding these can she put them aside and give full attention to the patient's needs and be able to be objective in her understanding of the patient.

Questions that could be asked of the students that may enable them to understand and accept their own feelings are:

How did you feel before you went into the patient's room?

What are thoughts you have concerning these feelings?

What do you think this patient thought of you?

What are some of the reasons you think this?

What did you know about this person before you met her?

What reactions did you expect the patient to have?

How do you think these preconceived ideas affected the person and your feelings toward her?

Now that the student is beginning to understand and accept herself, let us look at the patient. I feel that students would like to be able to cope with the situation, but how? This is always the question. Give the students an opportunity to think and list problems this patient has. Some of these may be:

Apprehension	Loneliness
Anxiety	Aggression
Hostility	Insecurity

Ask the students why they think this patient has these problems. These might be:

Fear of death

Fear of a prolonged illness or of being an invalid

Lack of confidence in people

Financial problems

Being away from home and family

Feeling that no one cares about her

Feeling useless and being a burden

Planning Nursing Care

Discuss these problems and needs of this patient with the students. Ask how they think these needs could be met. At this point in the discussion, elaborate on psychiatric nursing concepts and attitudes in meeting emotional needs of patients. These concepts could be applied to any individual.

The following are some ways of meeting needs:

Full explanation of every procedure, medications, etc. Answer any questions truthfully.

Stay with her as much as possible. Be with her during new treatments and medications. Check on her frequently afterwards. Tell her when you will be back and be there.

Anticipate her needs. Remember what she asks for and learn why she may have asked for it. May have been upset by visitors, new procedure, pain, loneliness.

Teach her to do things for herself when possible, but don't leave her and give her the feeling that you are relieved of work.

Give encouragement, but not pity.

Listen to what she says. Ask leading questions and let her answer. When she asks questions, let her answer her own questions when possible.

The concepts to bring into this discussion are:

All behavior has meaning and purpose.

All behavior is learned.

Each patient is an individual and is to be respected as such, regardless of behavior.

The behavior of the patient is related to and affected by his past experiences as well as his present environment and his condition.

The communication of the person, both verbal and nonverbal, is rational when it is understood.

Observations of the nurse will be directed toward an understanding of the patient's behavior and will accept this to be an indication of his needs.

The nurse will respond to the patient as indicated by his needs.

The nurse will work towards creating a climate of trust and security for the patient.

These are thoughts and ideas of what could be done with role playing. Each instructor could use her own ideas or even specific patients in the hospital with students "acting out" what actually happened. Here a follow-up could be done by the students with the patient. Of course cooperation from the nursing staff and doctor would be necessary before any effectiveness of continuity of care could be seen.

Another idea would be to work up a dialogue, have students act out the "poor" method and "good" method; then let the other students discuss the nursing care in each play while the instructor looked for psychiatric nursing concepts and made the students aware of the fact that these are psychiatric nursing concepts.

Everyday in nursing literature we are all made more aware that patients are individuals and that nursing care is directed towards this. The physical and technical nursing care given a patient has little value or meaning unless the emotional needs are understood and cared for. Let's face the fact that most people care little if the corners of the bed are at a perfect angle, or if the bath cloth is folded exactly, unless the nurse shows care, sincerity, interest, understanding of the patient as an individual who is worthy of being cared for in such a manner. Why do we as nurses and instructors spend so many hours with our students to make sure they know exactly how to make a bed, give a bath, an enema, etc., and so little time teaching and helping them understand themselves and their patients as people.

(b) **Concept**

All behavior is meaningful and has purpose

Situation

A conference table is being utilized for morning report in a general hospital. The night (11–7) nurse on a GYN surgical floor of 20 patients is reporting to the following nursing service personnel: one registered nurse, two licensed practical nurses, one aide, two practical nursing students, and the practical nursing instructor.

The night nurse says in the course of the report, "Room 204, Mrs. A., 35 years old, hysterectomy, five days postoperative, had a poor night. She was not in pain, but she sure put us in pain. She kept her signal light on most of the night asking for *things*. Once she even forgot why she rang. She is a real crock."

The instructor has assigned one of her students to Mrs. A. for morning care. The student's attitude is obvious by the expression on her face and she remarks, "Why do I have to be assigned to this patient?" The instructor realizes that the patient needs help and that her student will need help in order to assist the patient. The patient, by her actions of constantly turning on the light, is trying to communicate a need, but what? There may have to be several attempts made by the student, under the guidance of the instructor, to find the root of Mrs. A's problem.

Suggestions for Conducting Role Playing and Discussion

Re-enact the morning report as given by the night nurse.

Re-enact a flashback of what actually occurred during the night between Mrs. A. and the night nurse. The lack of understanding by the night nurse of Mrs. A's nonverbal communications should be emphasized.

Assign the students to the following parts:

The night nurse that gives the report

Mrs. A., the patient

The student practical nurse assigned to Mrs. A. for morning care.

The instructor might play her own part, but assist any three of the students as necessary.

Have the group discuss the emotional stress and fears that a hysterectomy might cause in a 35-year-old woman. Develop understanding in the group as to how this night nurse failed to support Mrs. A. emotionally.

The following concepts should be recognized as being useful in responding to Mrs. A's behavior and meeting her emotional needs:

The patient is a human being who needs to be respected as a person, regardless of his behavior.

The behavior of the patient is related to and affected by his past experiences as well as his present environment and his condition.

The patient's communication, both verbal and nonverbal, is rational when it is understood.

The patient must have the right to be as sick as he needs to be, to express his negative as well as his positive feelings, and to be assured of support in working toward solutions of his problems at his own pace.

Observations of the nurse will be directed toward understanding her patient's needs and learning to accept his behavior as an expression of these needs.

Following the discussion, replay the nurse-patient interaction as it might have occurred if the nurse had utilized these concepts.

INTERACTION NOTES

Concept

Anxiety results when self-esteem is threatened.

Objective

To provide concrete examples of how skill in observation and communication can be developed through the use of interaction notes.

The Patient

Mrs. J. is a 53-year-old Caucasian widow, who weighs about 200 pounds. She has one son who is married. She lives alone and her only income is from a government pension.

Diagnosis on Admission

Was admitted with a provisional diagnosis of Thrombophlebitis (L) leg. Left leg swollen, red and painful. History and physical findings revealed a Ureterostomy and Colostomy resulting from cancer of the cervix.

Orders

Bed rest, wrap left leg with ace bandage, elevate leg on two pillows, Zinc Oxide ung. to macerated area. Heat lamp 20 minutes q.i.d.

Notes

These interaction notes were written by a junior practical nurse student during the time she was caring for Mrs. J.

Morning following admission:

I reported to Mrs. J's bedside and asked her how she felt. After a sigh, she replied, 'I'm in a mess, look here honey at this bag, it's leaking.' I asked Mrs. J. to move closer to me so I could check the bag. Mrs. J. continuously minded me to be careful and don't pull the catches off the bag because she didn't want her belt wet. At the same time, she directed my attention to the irritated area around the Ileal Bud. Apologetically, she said, 'I'm not trying to tell you what to do, but don't take

the bag off unless you have some cement to put it back on with, you know that cement holds it on; I guess I have put too much on trying to keep dry.'

Just prior to leaving to empty the ureterostomy bag and clean it, Mrs. J. said, 'Hurry, hurry now, these sponges won't last long because the urine runs out so fast.' I gave Mrs. J. a large package of sponges to place over the area while I was gone. She grasped my hand and said, 'How does it look?' I told her there was some irritation present, but the physician had left an order for heat to be applied for 20 minutes four times a day and the application of a soothing cream.

Later: When I returned from the utility room, Mrs. J. asked me if this cream would keep the bag from leaking; I told her the cream was a soothing agent for her skin, but we would keep her bag emptied and it would not leak. Quickly she said, 'Hurry, honey, give me a sponge, it's leaking again and it smells so bad. You know I can't do for myself because of this leg. I hope nobody else will have trouble like this. Do you see many people like this?'

I told Mrs. J. that we had other patients with similar problems, but she would feel better after her care was completed. During the bath, Mrs. J. told me she was doing fine in establishing regularity of her colostomy and had worked very hard keeping dry until her leg suddenly started giving her trouble. She said the doctor told her a blood clot was in her leg. Shortly after this statement, the medication nurse entered the room and asked Mrs. J. if the doctor told her she would be getting Heparin.

Mrs. J. turned to the nurse and asked her, 'What's that?' The nurse replied, 'This is a medicine to dissolve clots, the doctor will tell you more about it.' Some medications were given Mrs. J. at this time, then the nurse left. As I continued in Mrs. J's care, she turned to me and said, 'Blood clots will kill you, won't they?' a pause, 'I'm sorry I'm so much bother to you.' She grasped my arm and looked at me, then a sigh. I replied to Mrs. J. that modern treatment for this condition had proven very successful; she looked away. I cleaned the irritated area around the Ileal Bud and applied the heat lamp.

Twenty minutes later, the lamp treatment was discontinued. Her leg was wrapped, back rub given, bed made, leg elevated on two pillows and I left to get her some juice. When I returned, Mrs. J. was fast asleep.

I acquired a great deal of respect for Mrs. J. She was making an effort to regain a healthy independence. The only thing that she did to make me feel uncomfortable was that she was always impatient; she wanted everything done in a hurry and if things took too long, she would begin to cry and complain, saying 'I wish you had never started unless you intended to finish.'

I believe Mrs. J. will make a better adjustment when she learns to manage her ureterostomy. Diversional activities will also play a part in this.

Interaction Notes in Teaching

Interaction notes are used to help in teaching the student to observe and listen more closely and to become more aware of her own feelings and the way expressions of her thoughts and feelings may affect the patient. The student must have time to prepare her notes, and to review these with the instructor. Whenever possible, the student should be assigned to care for one patient two or more days consecutively to allow her the opportunity to use the knowledge and insight she has gained to plan effectively for meeting the nursing needs of the patient.

The student was aware of Mrs. J's concern about her ureterostomy, and said that she felt this was due to a fear of rejection because of the urine odor, fear of helplessness because of her inability to get up to keep herself dry, and fear of death because of the blood clots in her leg. She observed that Mrs. J. always looked closely at her to see how she reacted as she gave her nursing care, so she always tried to be very careful about her facial expression and tone of voice. She said that when she helped Mrs. J. with the irrigation of her colostomy, Mrs. J. looked at her and said, "I sure hate that you have to clean that up."

The student felt that she was making a special effort to let her know that she appreciated the care and attention she gave her because she repeatedly told her about how nice a Negro nurse at Bethesda Hospital in Maryland had been when she was hospitalized there.

If the nurse is to intervene successfully to allay or reduce a patient's anxiety, she must recognize that her patient is anxious. She can then help the patient talk about how he is behaving, help him recognize how his behavior is an expression of his anxiety, help him re-evaluate the threat behind his anxiety and learn new ways of dealing with the threat. The knowledge and understanding that anxiety does not occur *only* in patients but that all people experience varying degrees of anxiety in their daily lives can be communicated to the patient to help him re-evaluate his anxiety and accept it as an appropriate expression as he progresses toward health.

The Concept of Anxiety

Every person needs to see himself as having the ability to satisfy his basic needs and wants, to control himself and his environment to a degree, to communicate in a meaningful way with others, to be useful and productive, and to achieve the goals and expectations he sets for himself. These needs are aspects of the self-image. If a person confronts a situation that threatens his self-image, he experiences anxiety.

Disease and the treatment of disease confront the patient with many threats. Among these are death, pain, economic distress, loss of identity, loss of democratic privileges, loss of cultural conventions, such as toilet habits and privacy, loss of mobility, inaccessibility of vital information and, in some instances, deprivation of the comfort of loved ones.

The degree of anxiety a person experiences is dependent upon the severity of the threat. Although it is difficult to define the nature of anxiety exactly, it is usually not difficult to recognize the manifestations. Sometimes there are physical signs (rapid pulse, cold clammy skin, etc.). Sometimes it is the way a person acts. Anger, complaining, constructive action, crying, denial, defensive behavior, irritation, panic, quarreling, restlessness, sullenness and withdrawal are all reactions that may be evoked by anxiety.

Any person confronted by or anticipating a situation that he perceives as threatening will experience anxiety. Anxiety provoked by a realistic threat is normal anxiety. Anxiety provoked by an unrealistic or imaginary threat is neurotic anxiety. When anxiety is neurotic and the threat confronting the person is an imagined one, it is still very real and requires attention.

LECTURE-DISCUSSION-FILM

Concept

Anxiety represents the individual's response to his perception of his condition, environment or situation.

Teaching Aids

Films

"Mrs. Reynolds Needs a Nurse" — 38 minutes—Black and White

Shows the problems involved in caring for a "difficult" patient. Free loan from Smith, Kline, and French Laboratories.

"The Third Eye"—27 minutes—Black and White

Story of a young nurse who is target of the provocative behavior of a hospitalized emotionally disturbed young man. Free loan from Smith, Kline, and French Laboratories.

Information Sheets (made by individual instructors)

Methods of Evaluation

Class Participation

Reports—written and/or oral

Tests

Planned observation of student in clinical area

The Nature of Anxiety

Anxiety is a state of apprehension, tension, uneasiness or uncertainty associated with the anticipation of danger, the source of which is largely unknown or unrecognized. Anxiety can be produced by any situation that threatens the individual's identity or self-image, or causes him to feel hopeless, isolated or insecure. Anxiety occurs in degrees and is a reaction to something that is perceived or felt to be a danger. When experienced, anxiety is indistinguishable from fear, but unlike fear, it does not occur in response to a specific environmental threat. Individuals experiencing anxiety describe it as a vague, uneasy feeling of dread, nervousness or apprehension.

Anxiety is a motivator of behavior and acts as a stimulus to defensive action to handle the excitation. The behavior may be an effort to deal with the threat by flight; it may be an effort to avoid facing up to the threat by flight; or it may be a means of expressing some of the feelings associated with the anxiety.

Anxiety is evoked by a threat to a person's self-image or the anticipation of loss of esteem either by one's self or others.

Anxiety may be regarded as pathological when it is present to such an extreme as to interfere with effectiveness in living, the achievement of desired realistic goals or satisfactions, or reasonable emotional adjustment.

All of us encounter anxiety in the course of our daily lives. Anxiety is likely to be a predominating factor associated with illness and hospitalization. It is important to recognize that no matter how the patient defends himself from anxiety and hurt, no matter how he reacts to illness and hospitalization, underneath are all of the human anxieties and fears. We must try to understand the nature of a patient's struggle in order to help him find constructive ways of effectively coping with the threatening situation.

Indications of Anxiety

Physiological Reactions

rapid pulse
difficulty in breathing
trembling
restlessness—pacing the floor—general fidgeting
sweating
cold extremities
nausea, vomiting
loss of appetite
sleeplessness

Emotional Reactions

demanding
critical
irritability
hostility
withdrawal
agitated
quarrelsome
rejection of attention
weeping
depression

Feelings of the Patient

Feels alone.

Feels helpless, dependent, and at the mercy of others.

Afraid of arousing criticism or contempt by saying or doing something humiliating while medicated or anesthetized.

Embarrassed by necessity of performing personal intimacies in public.

Dread of probable outcome of the illness or surgical procedure.

Frightened by the treatments, medications, etc, he is receiving.

Irritated by noise.

Guilt feelings that personnel feel patient is not trying.

Afraid of appearing weak.

Feelings of Personnel

Feelings of personal inadequacy.

Fear of loss of emotional control.

Role of the Nurse in Alleviating Anxiety

Spend time with patient.

Listen and offer comments which will encourage patient to express feelings.

Give calm, simple explanations of treatments, tests and what is being done (as it is about to occur).

Include patient in his care by explaining what patient is going to do (the expectations of him) and defining limits.

Do not use technical terms.

Try to fulfill needs with as little delay as possible.

Minimize environmental stimuli.

Introduce patient to personnel.

Inform patient as to geography of ward, floor, etc.—meals, bathroom, etc.

Give *specific* information only when patient asks for it.

Do not discuss any patient within hearing of other patients or visitors.

Do not demand more of the patient than he can meet.

Nurse needs confidence in herself and her ability.

Do not depersonalize patient into a diagnosis, room number or doctor so-and-so's patient.

Do not focus on patient's weaknesses—concentrate on the individual's strengths.

Let patient be dependent and help him toward becoming independent.

Avoid being judgmental.

Reassure by showing interest in patient as a person, by attention to matters that are important to him, and by allowing him to be as sick as he needs to be.

NURSING CARE GUIDE

A nursing care guide may be used to help the student assess the physical and emotional needs of a newly admitted geriatric patient.

(a) Concept:

All behavior is directed toward maintaining self-esteem.

Situation:

Miss Jones, a practical nurse student, is assigned to care for a newly admitted geriatric patient in a 190-bed nursing home. Mrs. B. is 86 years old. Her mind and body have undergone changes common to a person of her age. Her eyesight is poor and she refuses to wear her dentures. Mrs. B's husband died three months ago. Since his death, Mrs. B. has become severely depressed. The family physician advised Mrs. B's son, John, to place her in the local nursing home. Although the personnel is friendly and kind to Mrs. B., she still refuses to cooperate with them, and at times she becomes hostile. Her only son is unmarried and finds it difficult to accept Mrs. B's present mental condition.

PATIENT'S NEEDS	STUDENT'S ACTIONS	INSTRUCTOR'S ROLE	CONCEPTS AND FACTS BASIC TO UNDERSTANDING NEEDS
Emotional and psychological needs	Accepts and tries to understand the patient's behavior	Emphasizes: – Attitudes are our moods and feelings – Verbal and nonverbal communications – Interviewing techniques	Patients are beings of human worth and dignity – Behavior is affected by past experiences – All behavior has purpose
The need for love, acceptance and to feel wanted	Shows empathy, warmth and interest in patient's welfare		Self-esteem and self-preservation are enhanced by consistent flow of warmth, strength and concern from within
Need of a therapeutic environment	Searches for and establishes satisfactory rapport – Encourages self-care and independence – Recognizes accomplishments – Removes environmental hazards	Guides student in directing emotional tension into constructive channels	Impairment of special senses increases the feeling of insecurity and suspicion Predisposing factors, hidden vectors and oppressed feelings hinder rehabilitation

Socio-economic needs – Spiritual guidance – Feeling of unworthiness and familial rejection	Encourages patient to attend Bible study and pastor's visits Prepares for son to take mother for ride Invites friends to visit Spends time with patient Suggests hobby or some diversional activity	Discusses role of social worker and therapist Discourages over-protection and dependency	Cultural and spiritual concepts are one's own rights Following separation, comes anxiety, then depression, all follow disappointment or loss of loved one
Daily physical needs – Personal hygiene – Elimination	Assists with bath and care of personal effects Assists in maintaining proper elimination	Reviews the aging processes of – Digestive system – Urinary system – Characteristics of normal and abnormal excreta	Physical and emotional health are inseparable
Nutrition	Considers likes and dislikes, foods and fluids intake Encourages use of her dentures and self-feeding Serves tray attractively	Discusses menu planning and diet	Well-balanced diet provides adequate nutrients – Appetite, salivary glands and gastric juices are affected by emotions
Adequate rest and sleep	Controls noise, lights, etc.	Discusses "sleep" medication: variation of sleep among age groups	Body cells require periods of decreased activity to restore themselves
Needs resulting from impaired health	Recognizes feelings of bitterness, emptiness and unbelonging – Encourages visits of patients with similar problems – Provides group participation – Remembers that the aged do not respond to "magic"	Points out clues of recurring depression – Insomnia – Anorexia – Loss of weight – Idleness – Careless in dress Reminds student of suicidal tendencies associated with depression	Low self-esteem is increased by bodily impairment Accept a realistic goal. Personality traits make up person's self-concept

NURSING CARE GUIDE *(continued)*

(b) Concept:

Behavior of patient is related to and affected by past experiences as well as present environment and condition.

Situation:

A four-year-old girl was admitted to the hospital for plastic surgery to her ears. She had been seriously burned. Several painful operations had already been done so she was very apprehensive and cried every time a nurse entered the room.

NEED:	How Need was Demonstrated Pts. Reactions Nurses Observation	Planned Nsg. Care What can be done	Student's Participation What was done	Teachers Participation What was done
SECURITY:	Child cried every time a nurse entered her room. She was afraid that she would be hurt again. Her mother stayed with her constantly, but she was still very apprehensive and fearful.	The child's favorite toy was her teddy bear. It stayed in her bed at all times. We decided we could best reach the child through this toy. We would tell her that her teddy bear would have the same operation, have his ears bandaged. Go to and return from surgery with her.	Miss Jones went in and helped bandage the teddy bear's ears and every time she came in the room made some remark about how well he was progressing. This child's behavior changed completely. Instead of crying, she would beam and say, "Look at Teddy, he looks like me!"	I asked the child the day before surgery if she would like us to bandage her Teddy's ears and then he would have an operation too. She laughed for the first time and said, "Oh Yes!" The student and I did this and from then on, no more problems! We received a note of appreciation from the mother. She stated that the child's attitude about hospitalization had changed completely and that she was actually looking forward to her next surgery so "Teddy can be operated on too!"

References—Appendix D

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APPENDIX E

STATE WORKSHOP FOR PRACTICAL NURSE EDUCATORS

PURPOSE

To provide learning experiences which will enable the practical nurse educator to identify the mental health and psychiatric nursing concepts appropriate to practical nurse curriculum.

SETTING

A psychiatric treatment facility.

TIME

5 – 10 days

CONTENT	METHOD
Orientation to workshop program	Member of nursing faculty
Philosophy of the agency treatment program	Lecture-discussion—administrative staff
Introduction to clinical assignments	Faculty-trainee groups
Personality growth and development	Lecture-discussion—clinical psychologist and workshop faculty
Psychiatric treatments	Lecture-discussion—led by a psychiatrist
Psychiatric nursing trends	Lecture-discussion—led by psychiatric nurse
Clinical assignments	Select patient; prepare interaction notes; discussions and group conferences; staff meetings; patient group activities
Trends in mental health programs	Program director
Films and discussion	
Summary and evaluation	

APPENDIX F

WESTERN STATE HOSPITAL—PHILOSOPHY AND STRUCTURE OF THE TREATMENT PROGRAM

Dr. Druff and Members of the Staff

Dr. Druff:

Western is the fifth state mental hospital built in the United States. There are two sites at present—1,800 patients at the Old Site, which was built in 1825, and 1,200 at the New Site three miles East of Staunton.

Patients are admitted to each of the six units at the New Site. Each unit consisting of four wards, is staffed by a physician, a nurse and attendants. We are moving toward a policy of admitting all patients from a geographic area to a unit.

Many understaffed wards are filled with patients receiving mostly custodial care, but we are trying to implement a number of the changes suggested in *Action for Mental Health*, Report of the Joint Commission on Mental Illness and Health, 1961.

Many of the recommendations in the report are not altogether new concepts. We have recently found correspondence and annual reports written by Dr. Stribling, the first Superintendent of Western State, in the 1860's. Descriptions of the kind of work being done with patients suggest that we must work to get to the level of patient care of that period. The results obtained without tranquilizers were comparable to what we are doing with tranquilizers.

Dr. Stribling emphasized work therapy strongly, but the work of patients should not be primarily to get hospital work done. When a patient goes to work here he is paid for it, but financial support and personnel who are concerned about referring patients to jobs they want to do, or can learn and profit by, are not easy to come by. We have recently evaluated all jobs, and referrals to work are now discussed by the staff before work assignments are made.

We now have a small CHIRP (Community-Hospital - Industry Rehabilitation Program) program, but this needs to be supplemented by vocational rehabilitation.

We also have a hospital improvement grant from the National Institute of Mental Health. This has made it possible for us to get help from the University of Virginia Medical School to provide better physical care for our patients. We are concerned about changing attitudes to give people a better understanding of mental illness and to remove a number of misconceptions that exist in the community. Many of these misconceptions also exist within hospitals.

One of the major deficiencies in assuring a therapeutic environment for patients is the lack of competent supervision at the ward level. We are finding that the licensed practical nurse does this well, so we believe that the role of the LPN is crucial to promoting and establishing concepts of care which are truly therapeutic. Most of the therapy in hospitals like this, now and for a long time to come, will be done on the ward level. The psychiatrist is able to do a limited amount of group psychotherapy, but this is not effective if the ward environment is not favorable. Licensed practical nurses will, in the future, have an increasingly important role in improving nursing services in state hospitals.

One of your major tasks here, and an important purpose of this workshop, is to get more practical nurse students interested and prepared to improve the physical and psychiatric care of patients. We hope you will look carefully at what we are trying to do, and give us the benefit of your experiences. We have a dedicated staff whose members are not afraid

of criticisms and who will welcome your suggestions.

Discussion—Dr. Druff and Trainees:

Is there any possibility that some of the patients could get help from vocational rehabilitation to further their education during hospitalization?

Yes — This is part of the program we have planned. We need a vocational rehabilitation counselor on every unit. The Woodrow Wilson Rehabilitation Center nearby has a drop-out rate of about 30 percent. Patients who need training should be screened better and tried on work situations before they are sent there to cope with an eight-hour day of training. We also need literacy training. When a patient becomes mentally ill, the stigma attached to him because of that makes for enough difficulty when he goes back to the community. If he has both the handicap of being an unskilled laborer and of being illiterate, this compounds his aftercare problem and his chances for remaining out of the hospital.

Does the hospital have an inservice training program for attendants?

Yes — We are also exploring the possibility of the local practical nurse school expanding by using some of our units for part of the clinical training. Inadequate clinical resources to expand the local school is a major problem.

The medical-surgical and geriatrics care and treatment units in state hospitals usually have not been evaluated for their potential use in practical nurse education. If there is a small community hospital and a state hospital in the neighborhood, it might be possible to plan educational experiences in such a way that the student receives adequate clinical instruction in all areas, plus the advantage of a substantially profitable increase in mental health and psychiatric nursing knowledge.

Students can also learn the value of ward administration as a therapeutic tool, giving leadership to a team, or creating a therapeutic climate. Nurses should be more aware of some of the anti-therapeutic things that are going on in the ward. I hope your faculty will put considerable emphasis on this.

Are professional nurses and licensed practical nurses in overlapping roles?

One of the major deficiencies, particularly in state hospitals, is that roles are not usually clearly defined. People should know what their responsibilities are, what is expected of them.

Professional Staff Presentations:

Nursing Services: Nursing personnel includes registered nurses, licensed practical nurses and attendants, with attendants making up the majority of ward staff.

The nursing care plan is a new development here, but we are trying to make a plan for all patients admitted. We first determine the information required to determine appropriate nursing care. Staff members on a ward review basic information about a patient, consider the treatment prescribed by the ward physician, discuss the plan and the patient with the nursing supervisor and arrive at a specific plan. The nurse attends staff meetings, so she has the benefit of the discussion of the patient's needs and his treatment. She should be able to plan nursing consistent with the patient's program.

In meeting the emotional needs of patients, nurses must work chiefly through other people in a state hospital, because most of their work is supervisory. There is some opportunity for direct patient contact, and the extent of this varies often with the interest and ingenuity of the individual.

Social Services: This department has nine staff members. The director supervises the Female Alcoholic Service. Other staff members prepare intake social histories and discharge summaries; request and send abstracts; talk with relatives of patients; attend staff meetings; work with patients referred by physicians,

nurses and others; assist the work therapy director to secure jobs for patients; and refer patients to aftercare services. Patients who return to their family physician's care assume responsibility for making their appointments, but the department sends an abstract if either the physician or patient request it.

Patients are referred to mental health clinics for aftercare services if a clinic is available. In some areas, public health nurses provide these services. They have a natural entree into the home, and they know many patients before they are hospitalized. They often furnish information about the home situation which is helpful in discharge planning. A few health departments help patients to get medicine.

Psychological Services: This department has four full-time staff members and one graduate student during the summer. The chief of the service is head of the Male Alcoholic Service. Members of the staff abstract data from patient records to prepare case summaries, perform psychological tests, interview patients, and report results of tests and interviews at staff conferences. Some studies are done, but there are not enough staff members at this time to do group therapy.

Occupational Therapy: The department is responsible for occupational and recreational program activities. If a patient is expected to be hospitalized for only a brief period and resume work either at the job he held prior to hospitalization or another, an effort is made to find an activity in the hospital which will keep him productive. However, unless he is interested in the activity selected, it does not really seem to contribute to his recovery.

A personal improvement class provides patients with an opportunity to practice applying for jobs. Staff members of other departments conduct application interviews and tests.

A course in public speaking has been set up in response to patients' expressed need. Crafts, activities, and other programs have only negligible value unless the patient achieves a higher level of behavior and productivity.

CHIRP (Community - Hospital - Industry Rehabilitation Program): Local industries—one of which is the Virginia Metalcrafters in Waynesboro—have set up shop equipment in a building on grounds. The company furnishes supplies to produce a finished or partially finished product. Patients are referred to the program by physicians, and receive pay for work (an average of about $1.50 per hour).

Vocational Rehabilitation: The hospital does not have a full-time counselor at the hospital at this time, but refers a limited number of patients to Woodrow Wilson Rehabilitation Center (a regional facility in the community) for training. An effort is being made to have personnel from the state vocational rehabilitation department assigned to full-time service at the hospital.

Work Therapy (Hospital Industries): Patients are assigned to hospital jobs, and paid for their work. The pay scale depends on the type of work, and the level of competence.

Volunteer Services: A 13-member Volunteer Service Council Board serves as a coordinating and policy making group. Volunteers are assigned to several areas within the hospital. They may assist in the nursing and social service departments working directly with patients or provide goods and services, such as refreshments for parties, gifts for patients without relatives, and music for dances, without being directly involved with individuals or groups of patients.

Nurses and attendants know what patients need and what should be done for them, so are really the most important members of the staff in establishing and maintaining volunteer services in the hospital.

Volunteers in Staunton help set up hobby projects and assist with occupational therapy, take patients out to lunch, to shop and to church.

A referral is sent to the local volunteer chairman when a patient is ready for discharge to a community having a volunteer service group. A volunteer in his home town is sometimes able to find a job and a boarding house or apartment for a patient who is ready for discharge. They contact patients to encourage them to keep clinic appointments, furnish transportation to the clinic and help needy patients secure medicine.

Inactive registered nurses in one community have recently volunteered their services to the county health department to work with aftercare patients.

PERSONALITY DEVELOPMENT

Dr. Jeffreys

In the layman's language personality is the ability to be elected president of the class, to sell vacuum cleaners from door to door, or display the Ipana Smile of Beauty. From the psychological or scientific point of view, everyone has personality and being popular is only one aspect of it. It has aspects of "I'm an honest person, I'm an angry person, I'm a good person, I'm a Christian." Personality is an all-inclusive term to describe the integrated whole of an individual. The experimentalist usually defines it as a concensus or an average of the way people act. A personality inventory of John says that he is an introvert, an extrovert, generous, stingy, strong, weak, secure, insecure, etc. Everyone will not agree, but there will be a more or less main body of agreement so that his personality can be defined on the average.

Personality has aspects which are universal. Everyone experiences hunger, thirst, love and fear. There are other ways in which we are like many, but not all others, and there are ways in which we are like no one else. A person does not exist in a vacuum, but in a real world. Sounds, sights, tastes, all the stimuli and messages we receive from outside make up our environment.

What is the environment of a person? The only environment is that which is actually experienced by an individual. There are lights, bells and inkblots in our environment, but people are more important in their effect on behavior. A person's perception of another is based on his particular experience with him, and this differs from another person's experience. All of you are hearing my voice, but there is no such thing as my voice. There are as many "my voices" as there are people in this room to hear me. When we sense something, we make something of it to give it meaning. If we are angry, we hear things differently than if we are happy. If we are insecure, we see things differently than if we are secure and confident.

Psychologists have been giving a great deal of attention to universals during the last 40 or 50 years, but are now turning more to cultural influences, placing emphasis on the unique. The particular way in which experiences combine themselves in the time span of a person's growth and development make unique combinations like fingerprints.

In this personal world or environment which influences us, we also see ourselves. Take a look at these statements—"I know that I am in this room," and "I know that Mary is in this room." You notice in the first statement there are two "I's" and they are used differently. The first "I" is a knowing, perceiving, acting "I." In grammar we call this a subject. The second "I" is that which is known, perceived and seen. The way in which we refer to ourselves in our own language indicates that we are aware of ourselves—we know who we are. This is what we mean by the self concept. Self is often confused with personality. Self has the same basic components as personality, but differs in that self is a part of the environment or personal world.

When we try to understand the behavior of other people, we ask, "How do they see themselves; what is their perception of themselves?" —and gradually evolve an answer to how a

person is picturing himself, or knows himself. Differences in self-perception and the perception of others constitute one source of maladjustment. As one moves through the world, the way he sees himself and the way others around him see him may cause conflicts and tensions which give rise to anxiety and maladjustment. We must have other human beings, as well as food and water, to cope with the world, so we tend to ignore or set aside many differences. Abnormal behavior is not merely a distortion or denial of reality, because if we look closely, we can see that some of the most profound distortions and denials of reality are done by "normal" people, who must do so to keep going and to reduce the number of conflicts.

BASIC CONCEPTS IN MENTAL HEALTH AND MAJOR PSYCHIATRY SYNDROMES

Dr. Grey

All behavior has purpose and meaning and concerns itself with self-esteem. When self-esteem is in jeopardy, we experience anxiety. Anxiety has two qualities. The feeling or emotional state includes aspects of something impending and unknown, which is dangerous, making one apprehensive. Anxiety also produces certain physiological changes, such as perspiring palms, increases in pulse rate and in blood pressure.

Fear is commonly seen as a reaction to obvious, objective danger, although fear and anxiety are fundamentally the same. If someone walks in the door with a shotgun in his hand, even if we don't know it is loaded, all of us react to what is perceived as a real danger.

It is necessary to deal with anxiety in some way to restore self-esteem and ability to function. Efforts to defend against anxiety may produce symptoms or simply increase the anxiety. If a person is so anxious that the tension must be discharged in some way, he may have an acute anxiety attack. If defenses are adequate, this will be transient; but if defense mechanisms are not adequate, he may disorganize into a psychosis, because the anxiety is not tolerable.

Some would suggest that an understanding of anxiety is adequate for an understanding of psychiatric problems. Anxiety relates primarily to relationships, to interpersonal situations. The psychoanalyst says that anxiety comes from inner or outer conflict. It is difficult to distinguish between these because the things which make for inner conflict are learned in an interpersonal situation. The so-called punishing superego—the conscience that won't let a person relax because he has to work and work and work or he will feel guilty about it—is learned.

Other areas of personality function of concern in mental health are the disruptive effect of such emotions as anger, guilt and grief.

In some groups, anger is not an acceptable kind of emotion either to have or to express. A youngster, for example, wants to take a swat at mamma—but this is not acceptable. If enough of this feeling is suppressed consciously, it may continue without a person being aware of it until he is no longer aware that he feels angry. In a person who becomes schizophrenic, this is frequently a part of what has happened. Feelings of anger are so powerful that these break through and a very angry, violent person acts out his feelings.

A feeling of guilt that one has done something wrong can be very disruptive. This is not quite the same as feeling shame. To feel shame is to feel unworthy. Recently some patients and attendants on two or three of the wards here were interviewed to help us get a picture of how ward living is structured, to learn who makes the rules about who gets the best seat in front of the TV, or who is left holding the bag when there is housecleaning to be done. We know that rules of group living evolve in any kind of situation where a lot of people are living and working together. In some situations it was found that a fair amount of con-

formity was obtained by the use of shame which was sometimes very subtle. To a person who already has his self-esteem damaged by being a hospitalized mental patient, being shamed into being in line with ward routine is disastrous. Guilt which is misperceived responsibility is often seen in the depressed patient who feels that he has committed the unpardonable sin. Although he is feeling guilty inappropriately, the experience is devastating.

Grief is a normal reaction to loss, and is the most natural experience for everyone who loses, by death, a loved member of the family. Crying and feeling sad are appropriate. "Grief work" refers to that experience which the person must go through to get beyond his loss, come to terms with the reality of the situation, and reorient his life toward new relationships and activities.

Tenderness, the reaching out of a person to another, may be difficult to tolerate, but this is what all persons need and want. One of the things that is so striking in the schizophrenic patient is this difficulty. When they can talk about this, they will often say, "I don't want to risk getting hurt. I don't want to take a chance. Every time I have exposed myself I have been rejected."

Relationships and experiences may be therapeutic or anti-therapeutic. Therapeutic experiences are those in which a person can learn to trust another—an experience in which the self-esteem of a person is enhanced. An anti-therapeutic relationship is one in which the opposite happens. The relationship we want to build with a patient or teach another person how to develop is one which enhances the other person's concept of himself and makes him feel worthwhile.

In psychiatry we are concerned with all aspects and levels of communication. We use words to present concepts and ideas, but we also use a certain tone of voice or a certain sequence. The sarcastic remark says one thing in words and another in tone of voice. Gestures and body position are nonverbal aspects of communication. All of this is part of normal communication. In the abnormal communication of the schizophrenic patient, he may talk in symbols which are very personal, but there is meaning to what seems crazy or ridiculous if enough is known about what his experiences have been and what these mean to him.

A brief discussion of basic concepts is inevitably a biased, personal approach, which is incomplete. I hope this has been only the beginning which will whet your appetites for reading and discussion.

The psychoneuroses are clinical syndromes in which the person is partially overwhelmed with anxiety, feels inadequate or unable to cope with a situation, or handles his defense mechanisms in such a way that these produce symptoms. This person is in touch with reality, but feels inadequate to cope with it. The psychosomatic disorders are those accompanied by a lot of anxiety.

Personality or behavior disorders are those conditions in which the person has not reached a maturity of development to learn from experience, so his behavior is constantly getting him into difficulty. This group includes psychopaths, sociopaths, some of the criminals, addicts, and alcoholics.

Psychoses include thought disorders and effective disorders. The thought disorders include schizophrenic and paranoid psychoses. The affective disorders include depressions and mania.

Brain syndromes, chronic and acute, are conditions in which there are psychiatric symptoms because brain function has been damaged. These conditions may be acute, as in alcoholism, or chronic, as in arteriosclerosis or brain damage due to injuries. The primary functions interfered with are learning new things, judgment, memory and ability to orient oneself accurately.

ALCOHOLISM

Dr. Travis

An alcoholic is a person who drinks when he doesn't want to drink and this interferes with his way of life. He uses alcohol as a tranquilizer to calm feelings of anxiety, to fight feelings of depression or to avoid facing problems directly. The use of alcohol significantly or seriously interferes with his interpersonal relationships.

Six and one-half percent of the 76 million people in the United States who drink will develop alcoholism. More people die directly and indirectly as a result of alcoholism each year than the total for all other chronic illnesses. Absenteeism from alcoholism costs about $432 million a year. Treatment, most of which is now being done in local jails, costs the country about $2 billion a year.

Most of the five to eight million people in this country who have this problem are dying of the illness in varying stages without consulting a doctor.

Statistics do not show the loss of capabilities and the profound effect this illness has on families. For every alcoholic, four or five other people suffer. Fifty-two percent of the parents of alcoholic patients have a problem with alcoholism. Crimes associated with alcohol are the largest major arrest category in the United States. Many people view the alcoholic as a skid-row bum, someone lying in a gutter who doesn't work and who doesn't do anything, but even the skid-row alcoholic does productive work when he is sober, and he represents only about six percent of the total alcoholic population. The others are neighbors or friends whom we see as having a bit of a problem with drinking.

One of the major symptoms of alcoholism is a blackout, a period of alcoholic amnesia. A person may walk, talk and appear relatively normal during a blackout, which can last any period of time. Alcoholic hallucinosis and pathological intoxication (a state in which a person goes completely berserk and becomes unmanageable) are very serious conditions. Solitary drinking, sneaking drinks, lying about the amount of alcohol consumed and protecting the source by having bottles hidden in various parts of the house are other manifestations of alcoholism. Changes of behavior which are out of character, such as the use of sterno, canned heat, rubbing alcohol, perfume and toilet water differentiate alcoholics from social drinkers.

Like all illnesses there are secondary characteristics that develop during the process of the illness. These are described as the alcoholic personality. If we study pre-alcoholic personalities, we see that these characteristics are not really primary, but are common to almost all alcoholics. The alcoholic probably has the strongest feelings of inferiority of any patient. Many times he even seeks rejection. He uses two defense mechanisms. One of these is denial and the other is rationalization.

It is very important to work with the family. Studies indicate that the alcoholic does not get well unless the family becomes involved in therapy.

Alcoholics Anonymous is an organization which, if the alcoholic can accept the program, conducts an effective form of treatment, but less than one percent accept the program. This program puts stress on honesty, on admitting a problem that has made life unmanagable. It is strongly spiritual.

Antabuse is a drug used in treatment. It is a chemical barrier recommended to patients who can take it, not as a chemical guard, but to help them fight the illness. It can be used as a refresher to renew convictions not to drink and as a thermometer to help determine patterns of behavior that lead to drinking. A person must learn something about the problems that lead up to drinking if he is to handle these in another way. Antabuse can give him time to learn new patterns, and time is very important. Antabuse is useless if he thinks that it is some magic that will make him stop drink-

ing or cure his illness, or that if he takes it a year he can go back to social drinking. It is no substitute for therapy.

If a patient sticks to treatment he has 50 to 75 percent chances of recovery. If he does not, his chances are about one in eight.

DRUGS IN PSYCHIATRIC TREATMENT

Dr. Hanson

The current era of drug treatment in psychiatry began about 1953 with the introduction of reserpine (Serpasil), a rauwolfia compound, and cholopromazine (Thorazine). The rationale for drug therapy is believed to lie in chemical imbalances, defects in metabolism and enzymes. The value of the phenothizines, the basic class of drugs to which Thorazine belongs, is that it has a calming effect on subcortical centers and not on the cortex. It does not, to any great degree, affect thinking or consciousness.

The purpose of drugs in psychiatry differs from that of much of general medicine. The drugs are primarily used to affect target symptoms, not to be curative. Certain phenothiazines seem to have more effect on certain target symptoms than others, so it is important to evaluate the patient's symptomatology before a drug is prescribed. Overactivity of a purposeless nature; aggressive or destructive behavior; thought disorders, such as hallucinations, delusions, misinterpretations, paranoid ruminations and confusion, are target symptoms affected by the phenothiazines.

There is a tremendous variation in the dosage used. The aim is to keep the individual patient on the dosage producing the greatest effect with the least side effects for him.

The general practitioner may be reluctant to prescribe an adequate amount of medication for the psychiatric patient. A patient may be sent home from a psychiatric facility on 150 mgm. of Thorazine q.i.d. When his family physician reduces the dosage, there may be a gradual recurrence of symptoms.

Discussion—Dr. Hanson and Trainees:

How long are these drugs generally prescribed for a patient?

In emergency situations, the need for medicine may be limited to a week or a month. The chronically ill psychotic patient may be kept on a phenothiazine for years or possibly for life. We tell patients who are sent home on a maintenance dose that these drugs are not like aspirin. They take aspirin or morphine when they are having a particular symptom, but these medicines, like vitamin B12 and insulin, are taken to help one continue to feel well. Many patients are aware that if a diabetic stops taking insulin, he will not feel well, because the insulin is replacing something which he doesn't have in his own body. We feel that this discussion helps some patients understand why it is important to continue on phenothiazines. I believe that nurses should discuss medications with patients to help them learn the importance of taking it as prescribed. Patients on one ward here administer their own drugs. They get a supply for a week and take it as prescribed. There are other hospitals with many wards where this is done.

What aims of treatment determine selection of a particular drug?

One important aim is avoidance of sedation and apathy. Another aim is amelioration of ideational disorder, such as delusions, misinterpretations, hallucinations.

Are side or toxic effects common?

There are relatively few toxic symptoms with phenothiazines, but any kind of medicine can cause a blood dyscrasia. It is possible to get central nervous system depression beyond that desired. We must always be careful about the possibility, particularly in older individuals, of orthostatic hypotension. Constipation may be another problem. We also see patients with Parkinson-like symptoms—drooling, a par-

ticular gait, and the masking of facial expression.

Stelazine and Prolixin are likely to cause restlessness and overactivity, particularly in the first two or three days.

Thorazine may cause breast engorgement, lactation, and a change in the menstrual cycle. Patients taking Thorazine may sunburn severely.

It is important for nursing personnel to know the *early* signs of toxic reactions. Convulsions, as well as jaundice, agranulocytosis and skin eruptions are toxic effects of Sparine. In agranulocytosis, early detection can be the difference between life or death if the white count goes down at a tremendous rate.

When a patient on a phenothiazine complains of a sore throat, suddenly develops a lesion of the mouth, or has a sudden elevation of temperature, we should always suspect a toxic reaction to the drug. If a patient complains of itching or of change in the color of stools or urine, this should be called to the physician's attention. If there is difficulty in getting in touch with a physician, a nurse should discontinue a medicine she suspects might be causing a toxic reaction. The phenothiazines are not really lifesaving medicines, so if you have reason to believe there is an early toxic reaction, I would advise you to stop the medicine immediately on your own and get in touch with the physician as quickly as possible.

When you have a patient with an organic problem, may this contraindicate these medications?

What kind of organic problem are you thinking about?

I am thinking of glaucoma.

This is a difficult problem, so we work in very close cooperation with the ophthalmologist and try to find a dosage that does not seem to have too much effect on the glaucoma. We have had patients who are being treated for glaucoma on amounts of Mellaril up to 100 mgm. q.i.d. without any undesirable effect.

CURRENT STATUS OF PSYCHIATRIC TREATMENT

Dr. Lyon

The AMA has called mental illness the No. 1 public health problem. Fifty percent of all hospital beds are occupied by mentally ill patients on any day.

One out of ten persons are predicted to need psychiatric treatment during their lifetime.

A variety of traditional and ineffective treatment methods have been used, but notable improvements have been made during the last 30 years. Insulin coma was initiated in 1933. Convulsions, induced by medication in 1935 and by electricity in 1938, have been used extensively, and electroconvulsive therapy is still used by many physicians. Tranquilizers and antidepressants, introduced about 1955, are now used extensively.

A "mental illness gap" exists between what we *are* doing and what we *should be* doing:

> Five to ten percent of the psychiatrists treat 80 percent of the patients in state facilities—psychiatrists in private practice treat an estimated 20 percent of the patients.
>
> In 1966 more than three million people were treated for mental illness—about two million others sought treatment, but were denied it because of shortages of personnel or facilities.

To close the "mental illness gap" we need to:

> Do more research to find more effective drugs and other treatments.
>
> Change concepts of psychiatric treatment, include more people on the psychotherapy team and treat mentally ill people in groups.
>
> Detect illness early and treat on out-patient basis to avoid institutionalization as much as possible.
>
> Place treatment facilities in communities and make them readily available to everyone.

The Joint Commission on Mental Illness and Health (1955-61) recommended decentralization of large hospitals and establishment of community mental health centers offering comprehensive services.

Federal support for state planning, local construction, and staffing is now available. Ninety-two grants, totaling almost 42 million dollars, were awarded during 1965-66.

To qualify for grants, five essential services must be provided—in-patient, out-patient, partial hospitalization (day-care especially), consultation and education services to community agencies, and 24-hour emergency services.

Five additional services are desirable—precare, aftercare, training (not in-service), rehabilitation, research, and special diagnostic services.

Securing funds to match Federal grants and finding qualified staff are serious barriers to rapid development of these new services, but there are possible solutions:

Training program emphasis—more and bigger ones.

Public information programs to increase local support for psychiatric facilities. Volunteers can help.

Team approach emphasis—using all staff in psychotherapy programs (group therapy, psychodrama, remotivation)—natural outgrowth of a well-organized, well-staffed hospital.

Computers to handle paper work rapidly, freeing time of staff for treatment activities.

TRENDS IN MENTAL HEALTH—THE BROAD PICTURE

Dr. McPheeters

The mental health field is changing some of its traditional practices and patterns. Some factors that have led to changes:

An awareness that with the human being's natural tendency to health, a little support at the moment it is needed may be enough to restore the person to satisfactory functioning.

An awareness of the human dignity of the individual patient and a desire to encourage each patient to interact responsibly.

The knowledge that hospitalization not absolutely necessary may be traumatic and dehabilitating.

The use of psychotropic drugs which has given an optimistic therapeutic hue to all of our activity.

The awareness that other kinds of workers in addition to traditional mental health professionals can work effectively with disturbed people.

The knowledge that services to people were being seriously biased by economic, social and geographic factors.

A growing understanding and acceptance of mental disability by society at large leading to community acceptance of psychiatric services in the general hospitals, early release of patients, acceptance of limited psychiatric disability, etc.

The realization that there are not, nor can there ever be, enough psychiatrists, psychologists, social workers, psychiatric nurses, etc., to meet the needs of all of the population if we persist in traditional patterns of service.

A broadening concern of mental health field for human behavior within the framework of society rather than a narrow concern for psychosis and neurosis in the framework of the hospital or consulting room.

The growing appreciation of the effectiveness of scientifically conceived programs of prevention of emotional maladjustment and promotion of positive mental health.

An increasing official support of mental health by the New Frontier, the Great Society, state and local governments.

Changes in practices and patterns:

Treatment: The emphasis in *treatment* of mental illness has swung away from long-term, intensive treatment to *short-form* therapies. There is a realization that the effect is not as thoroughgoing, but that more sick people can be treated with a reasonably effective level of service.

There is an increase in emergency services, in the belief that if the patient can be given some immediate help at the time of his "psychological hemorrhage," the results may be more effective than if he is required to undertake longer treatment at some future time when his name comes to the top of the waiting list.

Many practitioners are finding *group work* and *family therapy* to be an effective way of rendering treatment services to more people. In some kinds of conditions group therapy seems to actually be more effective for individual patients than individual psychotherapy.

There is emphasis on a kind of *re-educational therapy* based on the principles of social learning theory that effective results can be obtained by teaching the patient new and more effective patterns of behavior.

There is a *shift in the location* in which treatment services are offered from state mental hospitals *to communities* in which patients live. This has increased psychiatric services in community general hospitals and is supporting current emphasis on developing community mental health centers.

Partial hospitalization for mental illness is increasing.

Rehabilitation: Another gratifying development is a major emphasis on *rehabilitation* of the mentally ill and the mentally retarded, the process of retraining to live in society. *Vocational rehabilitation* and *industrial therapy* programs are being started and expanded to focus on training in job habits, job attitudes, job skills, job counseling, and job placement. There is a growing awareness of the need for *social rehabilitation*, to retrain patients in grooming, budgeting, personal hygiene, home management, assuming responsibility and developing a personal sense of purposefulness.

Consultation: Psychiatrists, psychologists, psychiatric nurses, and social workers are helping persons from other walks of life to recognize and manage the problems of emotionally disturbed people in their work. Consultation services are the result of an awareness that we cannot expect to have enough qualified mental health workers to see all the people who need treatment services, and also an awareness that other professionals may already have a relationship with the disturbed person which can be used for therapy.

Prevention: We now see a more scientific and systematic approach to *prevention*. Preventive programs are carefully aimed at persons under some kind of stress.

Positive Mental Health: Efforts are more precise and scientific in the *promotion of positive mental health*. Programs of education and anticipatory guidance are being offered specific groups to help them to be more productive, more comfortable and more responsible in coping with the affairs of everyday living. These efforts are carried out through schools, Sunday schools, churches, industries, well-baby clinics, etc.

Community Development: Participation in community development has come to be a concern of the mental health movement. These are clearly *not* areas of primary mental health responsibility, but are areas in which our insights into human behavior should be considered.

Mental Retardation: In mental retardation, there is more emphasis on *community programs* than on institutional programs. There is greater interest in services for retarded *adults* and in *lifetime adjustment*.

Training: There is increasing interest in training the *traditional mental health professions* and for newer rehabilitation services such as vocational counselors, occupational therapists, chaplains and recreation specialists.

There is great concern with the development of middle level professional workers in mental health. These take many forms and precise patterns are not yet clear.

More work is being done in *inservice training* for all levels of staff workers. This training is both to improve knowledge and skills and to bring workers up-to-date with the newer knowledge.

Research: In *research* there are several current trends. One is greater concern with the *physiology, chemistry and pharmacology of* thought, emotion, behavior and mental illness.

Another is *behavioral science aspects of mental disorder*—the *roles of culture, society and economics.*

In *mental retardation* the greatest research focus is on the *biology and genetics of retardation*, but there is increasing concern *for cultural factors.*

There is increasing interest in *program evaluation.* How well are we doing with our present programs? Could we use our personnel or facilities better? Where do we need changes?

APPENDIX H

CONTENTS OF PACKET

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MENTAL HEALTH FILMS*

Child Development

"Bright Side"—23 minutes
Portrays how a family builds "emotional robustness" in their children.

Mental Retardation

"Clues for Timmy"—25 minutes
To help parents and teachers understand mental retardation.

Mental Health and Illness

"Anger at Work"—21 minutes
Explains displacement of anger on others and how this impairs efficiency.

"A Two Year Old Goes to the Hospital"—30 minutes
Behavior during 9 days in a hospital ward. *Excellent for all nursing students.*

"Mental Health"—12 minutes
Defines good mental health and sets forth some simple, straightforward rules for keeping mentally fit.

"Breakdown"—41 minutes
Shows insidious onset of mental illness in a young woman who gradually withdraws from work and social contacts.

"Psychiatric Nursing—The Nurse-Patient Relationship"—34 minutes
Shows experiences of a young nurse with a patient who has withdrawn to a world of fantasy.

"The 91st Day"—1 hour
Progressive regression of a patient whose intensive treatment is terminated after 90 days.

*These are usually available from either the State Mental Health Agency, the State Board of Health, or through the State or Local Mental Health Association.

APPENDIX I

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